129 CMR 2.00:
UNIFORM REPORTING SYSTEM FOR HEALTH CARE CLAIMS DATA SETS

SECTION

129 CMR 2.01 AUTHORITY

129 CMR 1.00 is promulgated in accordance with the authority granted to the Health Care Quality and Cost Council by M.G.L. c. 6A, § 16L.

129 CMR 2.02 PURPOSE AND SCOPE

This section contains the provisions for submission of health care claims data sets from third-party payers, third-party administrators, and carriers that provide only administrative services for a plan sponsor.

129 CMR 2.03 EFFECTIVE DATE

(1) Carriers that cover or administer a total of 2000 or more Massachusetts covered lives shall submit an initial dataset to the Council or its designee by December 1, 2007. The initial dataset shall contain data for claims paid during the period July 1, 2006 through September 30, 2007.

(2) Carriers that cover or administer fewer than 2000 Massachusetts covered lives shall submit an initial dataset to the Council or its designee by June 1, 2008. The initial dataset shall contain data for claims paid during the period January 1, 2008 through March 31, 2008.

(3) Carriers that provide stand-alone dental insurance shall submit an initial dataset to the Council or its designee by September 1, 2008. The initial dataset shall contain data for claims paid during the period July 1, 2007 through June 30, 2008.

129 CMR 2.04 DEFINITIONS

Unless the context indicates otherwise, the following words and phrases shall have the following meanings.

Address. Street address, post office box numbers, apartment numbers, e-mail addresses, web universal resource locator (URL) and internet protocol (IP) address number.

Bank account. Any checking, savings, certificate of deposit, or any account utilized for the payment of third parties.

Capitated services. Services rendered by a provider through a contract in which payment are based upon a fixed dollar amount for each member on a monthly basis.

Carrier. Any entity subject to the insurance laws and rules of Massachusetts, or subject to the jurisdiction of the commissioner of insurance that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health services, and includes an insurance company, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, third party administrator or any other entity arranging for or providing insured health coverage.

Clinical data. Health care claims and information about health care claims for services delivered in hospitals or other setting.

Co-insurance. The percentage a member pays toward the cost of a covered service.

Confidential agency data. Data collected or produced by the Council that:

(1) Has not been released publicly;
(2) Is not a public record pursuant to M.G.L. c.4, §7(26) and St.2006, c.58, §136; and
(3) Shall not, in the opinion of the Council, be released.

Confidential clinical data. Data provided to the Council that:

(1) Has not been revealed to the general public; and
(2) Relates to provision of medical or other services to a specific individual.

Confidential financial data. Data provided to the Council that:

(1) Has not been revealed to the general public; and
(2) Would directly result in the data provider being placed at a competitive economic disadvantage.

Consumer Assessment of HealthCare Providers and Systems (CAHPS®). A family of survey tools that measure patients' experiences with ambulatory and facility-level care and with health plans.

Co-payment. The fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

Council. The Health Care Quality and Cost Council, established by M.G.L. c.6A, § 16K.

Designee. An entity with which the Council has entered into an arrangement pursuant to which the entity performs data management and collecting functions, and under which the entity is strictly prohibited from using or releasing the information and data obtained in such a capacity for any purposes other than those specified in the agreement.

Direct Patient Identifier. Any information, other than case or code numbers used to create anonymous or encrypted data, that plainly discloses the identity of an individual, including:

(1) Names;
(2) Postal address information other than town or city, state and zip code;
(3) Telephone and fax numbers;
(4) Electronic mail addresses;
(5) Social security numbers;
(6) Vehicle identifiers and serial numbers;
(7) Personal internet ID addresses and URLs;
(8) Biometric identifiers, including finger and voice prints; and
(9) Personal photographic images.

Disclosure. The act of communicating information to a person not already in possession of that information or to using information for a purpose not originally authorized.

Encryption. A method by which the true value of data has been disguised in order to prevent the identification of persons or groups, and which does not provide the means for recovering the true value of the data.

Family. Spouse, children, parents, siblings, and legal guardians.

Financial data. Information collected that includes, but is not limited to:

(1) Costs of operation;
(2) Revenues;
(3) Assets;
(4) Liabilities;
(5) Fund balances;
(6) Other income;
(7) Rates;
(8) Charges; and
(9) Units of services.

Health care claims data. Information consisting of, or derived directly from, member eligibility, medical claims, and pharmacy claims. Health Care Claims Data does not include analysis, reports, or studies containing information from health care claims data sets, if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by the Council.

Health care claims processor. A third-party payer, third-party administrator, or carrier that provides administrative services for a plan sponsor.

Health care practitioner. Physicians and all others certified, registered or licensed in the healing arts, including, but not limited to:

(1) Nurses;
(2) Podiatrists;
(3) Optometrists;
(4) Pharmacists;
(5) Chiropractors;
(6) Physical therapists;
(7) Dentists;
(8) Psychologists; and
(9) Physicians' assistants.

Healthcare Effectiveness Data and Information Set (HEDIS®). The set of performance measures in the managed care industry that were developed and are maintained by the National Committee for Quality Assurance (NCQA) covering various areas of measurement from general health plan information to utilization rates.

Hospital. A licensed acute or specialty care institution.

Insured. An individual in whose name an insurance policy is carried.

Medical claims file. A data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to:

(1) Member demographics;
(2) Provider information;
(3) Charge/payment information; and
(4) Clinical diagnosis/procedure codes.

Member. The subscriber and any spouse and/or dependent who is covered by the subscriber's policy.

Member eligibility file. A data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

National Committee for Quality Assurance (NCQA). The private, not-for-profit organization that assesses and reports on the quality of the nation's managed care plans through an accreditation and performance measurement program, including quality of care, member satisfaction, access and customer service.

Non-hospital provider. A provider of health care services other than a hospital.

Pharmacy claims file. A data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to:

(1) Member demographics;
(2) Provider information;
(3) Charge/payment information; and
(4) National drug codes.

Plan sponsor. Any persons, other than an insurer, who establishes or maintains a plan covering residents of the state of Massachusetts, including, but not limited to, plans established or maintained by employers or jointly by one or more employers and one or more employee organizations, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

Prepaid amount. The fee for the service equivalent that would have been paid by the health care claims processor for a specific service if the service had not been capitated.

Privileged medical information. Information other than hospital, non-hospital health care facility, or health care claims data that identifies individual patients and that is derived from communications that were:

(1) Made for the purpose of diagnosis or treatment among a provider or health care, persons assisting the provider or patient, and a patient;
(2) Made for the purpose of payment of health care services among a provider of health care, a health care claims processor, and a patient;
(3) Not intended to be disclosed except to persons necessary to transmit or record the communication and persons participating in the diagnosis, treatment or payment; and
(4) Not previously disclosed to the general public.

Provider. A health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.

Release. To make data or information available for inspection and copying to persons other than the data provider.

Subscriber. The certificate-holder.

Third party administrator. Any persons, that, on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of the state.

Third party payer. A state agency or a health insurer, nonprofit hospital, medical services organization, or managed care organization licensed in the Commonwealth of Massachusetts that pays for health care services.

129 CMR 2.05 REPORTING REQUIREMENTS FOR ALL LICENSED CARRIERS

(1) HEDIS Reporting Requirements. Each carrier that collects data for use in calculating health plan employer data and information set managed care measures shall report those data that are collected and that pertain to Massachusetts resident members or subscribers who receive their benefits under a policy or plan issued in Massachusetts. The carrier shall use the NCQA tool for submission of HEDIS data.

(2) CAHPS Reporting Requirements. Each carrier that collects CAHPS survey data shall report those data collected that are collected and that pertain to Massachusetts resident members or subscribers who receive their benefits under a policy or plan issued in Massachusetts. The carrier shall use the NCQA format for submission of the CAHPS survey data.

(3) Health Claims Dataset. Each carrier shall submit to the Council, or its designee, a completed health care claims data set for all Massachusetts resident members who receive services under a policy issued in Massachusetts. Each carrier shall also submit all health care claims processed by any sub-contractor on its behalf. The health care claims data set shall include a member eligibility file, a medical claims file, and a pharmacy claims file.

(4) Health care claims processors may submit all of the data submissions required of carriers under this chapter, in accordance with the specifications included herein, to the extent permitted by law and contractual requirements.

(5) Exceptions to Reporting Requirements.

(a) Third party payers that write less than $250,000 in insured accident and health premiums in Massachusetts on an annual basis shall not be required to submit their health care claims data set, their HEDIS data, or their CAHPS survey data.

(b) Third party administrators that administer insured health insurance plans covering fewer than 200 Massachusetts lives in total shall not be required to submit their health claims data.

(c) Carriers shall not be required to submit claims for stand-alone insurance policies that cover only one or more of the following types of services; however claims for these types of services shall be included in the medical claims file submission if they are covered by a comprehensive medical insurance policy.

a. Specific disease;
b. Accident;
c. Injury;
d. Hospital indemnity;
e. Disability;
f. Long-term care;
g. Vision coverage; or
h. Durable medical equipment.

(d) In instances where more than one entity is involved in the administration of a policy, the health carrier shall be responsible for submitting the claims data on policies that it has written, and the third party administrator shall be responsible for submitting claims data on self-insured plans that it administers.

129 CMR 2.06 PROTECTION OF CONFIDENTIALITY

The Council shall ensure that it does not collect any Direct Patient Identifiers under 129 CMR 1.00. The Council shall institute appropriate administrative procedures and mechanisms to ensure that it is in compliance with the provisions of M.G.L. c. 66A, the Fair Information Practices Act, to the extent that the data collected there under are "personal data" within the meaning of that statute. In addition, the Council shall ensure that any contract entered into with other parties for the purposes of processing and analysis of data collected under 129 CMR 1.00 shall contain assurances such other parties shall also comply with the provisions of M.G.L. c.66A.

129 CMR 2.07 DATA FILING AND PENALTIES

(1) Filing Periods. The filing period for each claims data file listed shall be determined by the total number of covered lives who are Massachusetts residents for whom claims are being paid or processed by each carrier or health claims processor. For those carriers having 2,000 or more Massachusetts covered lives, data shall be submitted monthly. For those carriers having fewer than 2,000 Massachusetts covered lives, data shall be submitted quarterly.

(2) Testing of Files. At least 30 days prior to the initial submission of the files, each carrier shall submit to the Council, or its designee, a data set for determining compliance with the standards for data submission. The size, based upon a calendar period of one month, or quarter of the data files submitted shall correspond to the filing period established for that carrier.

(3) Rejection of Files. Failure to conform to the requirements for submission shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate, corrected form to the Council, or its designee, within 10 days.

(4) Replacement of Data Files. No carrier shall replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period shall be approved by the Council. Individual adjustment records shall be submitted with a monthly data file submission.

(5) Penalties. If any carrier fails to submit required data to the council on a timely basis, or fails to correct submissions rejected because of excessive errors, the council or its designee shall provide written notice to the carrier or health care claims processor. Pursuant to M.G.L. c.6A, §16L(d), if the carrier or health care claims

processor fails, without just cause, to provide the required information within 2 weeks following receipt of said written notice, the Council may require the carrier to pay a penalty of $1,000 for each week of delay; provided, however, that the maximum penalty under this section shall be $50,000 per year. The Statistical Plan developed pursuant to 129 CMR 1.08 shall include the standards the Council or its designee will use to assess penalties for failure to submit required data, and shall define "just cause" for delays in providing required data.

129 CMR 2.08 COMPLIANCE WITH DATA STANDARDS

(1) Statistical Plan. The Council shall approve and publish a Statistical Plan.

(a) The Statistical Plan shall include the methodology to be used by carriers to create unique member identification numbers.

(b) The Statistical Plan shall include the edit specifications that the Council or its designee will use to verify the accuracy of data submissions, as well as the standards that the Council or its designee will use to reject submissions because of excessive errors. The Statistical Plan will specify the format of an edit report displaying detail for all errors found in a submission, as well as a summary report containing certain aggregate data for review and verification. The Council or its designee shall provide these reports to each carrier.

(c) The Statistical Plan shall include a method for carriers to submit a limited number of late claims paid during a prior submission period. The Statistical Plan shall include rules for submitting denied claims. The Statistical Plan shall include rules for submitting claims for medical services that include pharmacy codes.

(d) The Statistical Plan shall list the HEDIS and CAHPS measures that carriers are required to report.

(e) The Statistical Plan shall include steps that carriers must take by July 1, 2008 to begin collecting patient race and ethnicity data.

(2) Compliance. The Council, or its designee, shall evaluate each member eligibility file, medical claims file and pharmacy claims file to determine compliance with the Statistical Plan and the following data reporting requirements:

(a) The applicable code for each data element shall be included within the eligible values for the element;
(b) Coding values indicating "data not available", "data unknown", or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element, or determined allowable in the Statistical Plan;
(c) Member sex, diagnosis and procedure codes, and date of birth and all other data fields shall be consistent within an individual record; and
(d) Member identifiers shall be consistent across files.

(3) Notification. Upon completion of the evaluation, the Council, or its designee shall promptly notify each carrier whose data submissions do not satisfy the standards. This notification shall identify the specific file and the data elements that do not satisfy the standards.

(4) Response. Each carrier notified of a non-compliant data submission shall respond within 60 days of the notification by making the changes necessary to satisfy the standards.

129 CMR 2.09 CODING AND CLAIMS SUBMISSION RULES
Carriers shall file claims data in compliance with the following rules.

(1) Adjustment records. Carriers shall report adjustment records with the appropriate positive or negative fields with the medical and pharmacy file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

(2) Capitated services claims. Claims for capitated services shall be reported with all medical and pharmacy file submissions.

(3) Data fields. Carriers shall make every effort to report the data fields outlined in these requirements. However, if a field is not used for medical or pharmacy claim adjudication, is not captured on the carrier's transaction system (nor on that of its subcontractors), or cannot be derived reliably from other information available on the carrier's transaction system, the health plan shall notify the Council, or its designee, and shall identify the field that cannot be provided. After notification, the carrier shall not be required to populate that data field in its reports. The carrier shall report on an annual basis its efforts to populate this field, and the expected data as of which this field will be available, if there is such data.

(4) Code sources. Unless otherwise specified, the member eligibility file and medical and pharmacy claims files submissions shall use the code sources listed in 129 CMR 1.10.

(5) Member Identification Codes. Carriers shall assign, according to a standard algorithm provided by the Council, or its designee, a unique identification code to each of their members using the method developed by the Council or its designee.

(6) Specific/Unique Coding. With the exception of provider codes and provider specialty codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(7) Rules Governing Claims Submissions.

(a) Claimant and member records. Claims records and member records for medical and pharmacy claims shall be reported only for Massachusetts resident members who receive their benefits under a policy or plan issued in Massachusetts.

(b) Claim records. Records for medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical, and pharmacy claims shall be based upon the paid dates and not upon the dates of service associated with the claims.

(c) Co-insurance/Co-payment. Co-insurance and co-payment are to be reported in 2 separate fields in the medical and pharmacy claims file submission.

(d) Coordination of Benefit Claims. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

(e) Version Number. When more than one version of a fully-processed claim service line is submitted, each version of a claim service line shall be enumerated sequentially with a higher version number (MC005A) so that the latest version of that service line is the record with the highest version number (MC005A) and the same claim number + line counter.

(f) Fully-Processed Claim Lines: Only fully-processed claim service lines that have gone through an accounts payable run and been booked to the health plan ledger shall be included on medical and pharmacy claims data submissions.

(g) Subsequent Incremental Claims. Subsequent incremental claims submissions shall include all reversal and adjustment/restated versions of previously submitted claim service lines and all new, fully-processed service lines associated with the claim, provided that they have paid dates in the reporting period:

1. Each version of a claim service line shall be enumerated sequentially with a higher line version number (MC005A); and
2. Reversal versions of a claim service line shall be indicated by a claim status code = '22' (Field MC038).

(h) Eligibility Records. Records for the member eligibility submission shall be reported at the individual member level so that:

1. Members without medical and/or pharmacy coverage during the month reported shall be excluded;
2. If a member is covered as both a subscriber and a dependent on 2 different policies during the same month, 2 records shall be submitted; and
3. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records shall be submitted.

(i) Retroactive Changes. For the purpose of capturing retroactive changes, carriers shall not be:

1. Required to resend eligibility data for a prior reporting period; and
2. Considered errors in the submitted eligibility data.

(j) Quarterly Submission of Data. Carriers that submit data quarterly shall:

1. Include one member record for each calendar month in which a member was covered; and
2. Submit one record for each reporting month in which the member was eligible for medical or pharmacy benefits for one or more days.

(k) Behavioral or Mental Health Claims. All claims related to behavioral, mental health, or substance abuse shall be included in the medical claims file.

(l) Medicare, Tricare or Other Supplemental Health Insurance. Claims related to Medicare, Tricare, or other supplemental health insurance policies are to be excluded unless the policies are for health care services entirely excluded by the Medicare, Tricare, or other program.

(m) Prepaid Amount. Any prepaid amounts shall be reported in a separate field in the medical and pharmacy claims file submissions.

(n) Detailed File Specifications. All carriers shall use the following file specifications in their submissions:

(1) Filled Fields. All fields shall be filled where applicable. Non-applicable text and data fields shall be set to null. Non-applicable integer and decimal fields shall be filled with one zero and shall not include decimal points.

(2) Position. All text fields shall be left justified. All integer and decimal fields shall be right justified.

(3) Signs. All signs (+ or -) shall appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals shall not be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB92, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file type shall conform to the file specifications described below.

129 CMR 2.10 REGISTRATION AND TRANSMISSION REQUIREMENTS

(1) Registration Form.

(a) Each carrier shall submit a registration form to the Council, or its designee. The Council shall develop and publish the registration form, and may make changes from year to year. The form shall contain the following information:

1. Company name;
2. NAIC code;
3. Mailing address;
4. Information about whether the company conducts health insurance related business;
5. Number of Massachusetts members covered; and
6. Name, e-mail address and address of the person completing the form.

(b) Carriers shall submit a registration form by October 1, 2007, and annually thereafter on a date specified in the Statistical Plan developed pursuant to 129 CMR 108.

(2) File Organization. The member eligibility files, medical claims file, and the pharmacy claims file shall be:

(a) Submitted to the Council or its designee as separate ASCII files; and

(b) Each record terminated with a carriage return (ASCII 13), or a carriage return line feed (ASCII 13, ASCII 10).

(3) Filing Media.

(a) Data files shall be submitted utilizing one of the following media:

1. CD-ROM;
2. DVD-ROM;
3. Secure SSL web upload interface; or
4. Electronic transmission through a file-transfer program.

(b) E-mail attachments shall not be acceptable.

(c) Space permitting, multiple data files may be submitted utilizing the same media. If this is the case, the external label shall identify the multiple files.

(4) Transmittal Sheet.

(a) All data file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information:

1. Identification of the carrier;
2. File name;
3. Type of file;
4. Data period(s);
5. Date sent;
6. Record count(s) for the file(s); and
7. Contact person with telephone number and e-mail address.

(b) The information on the transmittal sheet shall:

1. Match the information on the header and trailer records; and
2. Conform to the following layout:

Health Care Quality and Cost Council Data Transmission Form

Carrier Name:
_____

Council Submitter Code: _____

Contact Person Name:
_____

Address:
_____

_____

Telephone: _____ E-Mail: _____

File Name	Eligibility	Medical	Prescription Drugs
Period Beginning Date			
Period Ending Date			
Record Count			
Date Processed			
Original Submission			
Resubmission			

(c) In addition to the transmittal sheet, carriers submitting data on physical media shall affix an external label to CD-ROM or DVD on which data are sent that includes:

1. Health plan name;
2. Council submitted code;
3. Contact person name;
4. Contact person address;
5. Contact person telephone number;
6. Contact person e-mail address;
7. Shipping date;
8. Unique tracking identifier number for each file;
9. Period beginning date;
10. Period ending date;
11. Record count;
12. Date proposed;
13. Submission date; and
14. Any date of resubmission.

129 CMR 2.11 HEALTH CARE CLAIMS DATA FILING FORMAT

A. FILE FORMAT. Each data file submission shall be an ASCII file, variable field length, and asterisk delimited. When asterisks are used in any field values, they shall be enclosed in double quotes.

B. HEADER AND TRAILER RECORDS. Each member eligibility file and each medical claims file, and pharmacy claims file that is submitted shall contain a header record and a trailer record. The "Header record" means the first record of each separate file that is submitted and the "Trailer record" means the last record of each submitted file. The header and trailer record format shall conform to the following record specifications:

(1) Record Specifications. Carriers shall use the following record specifications in submitting their claims records:

a. The file header record layout shall be submitted using the following data elements:

1. HD001. This element is named "record type". The data type of this element is text. Its length is 2.

2. HD002. This element is named "payer". The data type of this element is text. Its length is 6. Carriers shall code according to payer submitting payments, Council submitter code.

3. HD003. This element is named "National Plan ID". The data type of this element is text. Its length is 30. Carriers shall code according to CMS National Plan ID.

4. HD004. This element is named "type of file". The data type of this element is text. Its length is 2. Carriers shall code according to ME member eligibility, MC medical claims, PC pharmacy claims.

5. HD005. This element is named "period beginning date". The data type of this element is integer. Its length is 6. Carriers shall code according to CCYYMM, beginning of paid period for claims, beginning of month covered for eligibility.

6. HD006. This element is named "period ending date". The data type of this element is integer. Its length is 6. Carriers shall code according to CCYYMM, end of paid period for claims, end of month covered for eligibility.

7. HD007. This element is named "record count". The data type of this element is integer. Its length is 10. Carriers shall code according to total number of records submitted in this file, with the header and trailer record excluded from the count.

8. HD008. This element is named "comments". The data type of this element is text. Its length is 80. Carriers shall code according to their own option.

b. The file header record layout shall conform to the following:

Table 1 File Header Record Layout

Data Element #	**Element**	**Type**	**Maximum Length**	**Description/Codes/Sources**
HD001	**Record Type**	Text	2	HD
HD002	**Payer**	Text	6	Payer submitting payments
				Council Submitter Code
HD003	**National Plan ID**	Text	30	CMS National Plan ID
HD004	**Type of File**	Text	2	MA Member Eligibility
				MC Medical Claims
				PC Pharmacy Claims
HD005	**Period Beginning Date**	Integer	6	CCYYMM
				Beginning of paid period for claims
				Beginning of month covered for eligibility
HD006	**Period Ending Date**	Integer	6	CCYYMM
				End of paid period for claims
				End of month covered for eligibility
HD007	**Record Count**	Integer	10	Total number of records submitted in this file
HD008	**Comments**	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

c. The trailer header record layout shall be submitted using the following data elements:

1. TR001. This element is named "record type". The data type of this element is text. Its length is 2.
2. TR002. This element is named "payer". The data type of this element is text. Its length is 6. Carriers shall code according to payer submitting payments, Council submitter code.
3. TR003. This element is named "National Plan ID". The data type of this element is text. Its length is 30. Carriers shall code according to CMS National Plan ID.
4. TR004. This element is named "type of file". The data type of this element is text. Its length is 2. Carriers shall code according to ME member eligibility, MC medical claims, PC pharmacy claims.
5. TR005. This element is named "period beginning date". The data type of this element is integer. Its length is 6. Carriers shall code according to CCYYMM, beginning of paid period for claims, beginning of month covered for eligibility.
6. TR006. This element is named "period ending date". The data type of this element is integer. Its length is 6. Carriers shall code according to CCYYMM, end of paid period for claims, end of month covered for eligibility.
7. TR007. This element is named "date processed". The data type of this element is date. Its length is 8. Carriers shall code according to CCYYMMDD, the date the file was created.

d. The trailer record layout shall conform to the following:

Table 2 Trailer Record Layout

Data Element #	**Element**	**Type**	**Maximum Length**	**Description/Codes/Sources**
TR001	**Record Type**	Text	2	TR
TR002	**Payer**	Text	6	Payer submitting payments
				Council Submitter Code
TR003	**National Plan ID**	Text	30	CMS National Plan ID
TR004	**Type of File**	Text	2	MA Member Eligibility
				MC Medical Claims
				PC Pharmacy Claims
TR005	**Period Beginning Date**	Integer	6	CCYYMM
				Beginning of paid period for claims
				Beginning of month covered for eligibility
TR006	**Period Ending Date**	Integer	6	CCYYMM
				End of paid period for claims
				End of month covered for eligibility
TR007	**Date Processed**	Date	8	CCYYMMDD
				Date file was created

C. MEMBER ELIGIBILITY FILE

a. The specifications for the member eligibility file shall be as follows:

1. ME001. This element is named "payer". The data type of this element is text. Its length is 6. Carriers shall code according to payer submitting payments, Council submitter code.

2. ME002. This element is named "National Plan ID". The data type of this element is text. Its length is 30. Carriers shall code according to CMS National Plan ID.

3. ME003. This element is named "insurance type code/product". The data type of this element is text. Its length is 2. Carriers shall code according to the following:

Table 3 Insurance Type Code/Product

Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12-month coordination period with an Employer Group Health Plan
14	Medicare Secondary No-Fault Insurance including Insurance in which Auto is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary Other Liability Insurance is Primary
AP	Auto Insurance Policy
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
EP	Exclusive Provider Organization (for self-insured risks)
HM	Health Maintenance Organization (HMO)

HN	Health Maintenance Organization (HMO) Medicare Advantage
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
SP	Supplemental Policy
WC	Workers' Compensation

4. ME004. This element is named "year". The data type of this element is integer. Its length is 4. Carriers shall code according to the year for which eligibility is reported in this submission.
5. ME005. This element is named "month". The data type of this element is integer. Its length is 2. Carriers shall code according to the month for which eligibility is reported in this submission.
6. ME006. This element is named "insured group or policy number". The data type of this element is text. Its length is 30. Carriers shall code according to the group or policy number and not the number that uniquely identifies the subscriber.
7. ME007. This element is named "coverage level code". The data type of this element is text. Its length is 3. Carriers shall code according to the benefit coverage level:

(i) CHD Children Only;
(ii) DEP Dependents Only;
(iii) ECH Employee and Children;
(iv) EMP Employee Only;
(v) ESP Employee and Spouse;
(vi) FAM Family;
(vii) IND Individual;
(viii) SPC Spouse and Children; and
(ix) SPO Spouse Only.

8. ME008. This element is named "encrypted subscriber unique identification number". The data type of this element is text. Its length is 30. Carriers shall code according to the encryption method developed by the Council or its designee. Carriers shall set as null if unavailable.
9. ME009. This element is named "plan specific contract number". The data type of this element is text. Its length is 30. Carriers shall code according to the encrypted plan assigned contract number. Carriers and health care claims processors shall set as null if contract number is the same as the subscriber's social security number.
10. ME010. This element is named "member suffix or sequence number". The data type of this element is integer. Its length is 2. Carriers shall code according to the unique number of the member within the contract.
11. ME011. This element is named "member identification code". The data type of this element is text. Its length is 30. Carriers shall code according to the encryption method developed by the Council or its designee, and carriers shall set as null if unavailable.

12. ME012. This element is named "individual relationship code". The data type of this element is integer. Its length is 2. Carriers shall code according to the member's relationship to the subscriber as shown on the following:

Table 4 Individual Relationship Code

Code	Description
01	Spouse
18	Self/Employee
19	Child
21	Unknown
34	Other Adult

13. ME013. This element is named "member gender". The data type of this element is text. Its length is one. Carriers shall code according to:

(i) M = Male;
(ii) F = Female; and
(iii) U = Unknown.

14. ME014. This element is named "member date of birth". The data type of this element is date. Its length is 8. Carriers shall code according to CCYYMMDD.

15. ME015. This element is named "member city name". The data type of this element is text. Its length is 30. Carriers shall code according to the city location of the member's residence.

16. ME016. This element is named "member state or province". The data type of this element is text. Its length is 2. Carriers shall code the state in which the member resides using the standard abbreviations established by the U.S. Postal Service.

17. ME017. This element is named "member zip code". The data type of this element is text. Its length is 11. Carriers shall code according to ZIP code of member's residence, which may include non-US codes. Carriers and shall not include the dash in the coding.

18. ME018. This element is named "medical coverage". The data type of this element is text. Its length is one. Carriers shall code according to:

(i) Y = Yes; and
(ii) N = No.

19. ME019. This element is named "prescription drug coverage". The data type of this element is text. Its length is one. Coverage for limited supplies only, such as diabetic test-strips, syringes, and birth control, shall be coded as "No". Carriers shall code according to:

(i) Y = Yes; and
(ii) N = No.

(a) ME020. This element is named "race 1". The data type of this element is text. Its length is six. Carriers shall code according to the Race Code below.
(b) ME021. This element is named "race 2". The data type of this element is text. Its length is six. Carriers shall code according to the Race Code below. If none, set as null.

Table 5 Race Code

Code	**Description**
R1	American Indian/Alaska Native
R2	Asian
R3	Black/African American
R4	Native Hawaiian or other Pacific Islander
R5	White
R9	Other Race
UNKNOW	Unknown/not specified

(c) ME022. This element is named "other race". The data type of this element is text. Its length is fifteen. Carriers shall enter patient race, if ME020 Race 1 or ME021 Race 2 is coded as R9 Other Race.
(d) ME023. This element is named "Hispanic indicator". The data type of this element is text. Its length is one. Carriers shall code according to:

(i) Y = Yes Patient is Hispanic/Latino/Spanish;
(ii) N = No Patient is not Hispanic/Latino/Spanish; and
(iii) U = Unknown.

(e) ME024. This element is named "ethnicity 1". The data type of this element is text. Its length is six. Carriers shall code according to the Ethnicity Code below.

(f) ME025. This element is named "ethnicity 2". The data type of this element is text. Its length is six. Carriers shall code according to the Ethnicity Code below.

Table 6 Ethnicity Code

Code	**Description**
2182-4	Cuban
2184-0	Dominican
2148-5	Mexican, Mexican American, Chicano
2180-8	Puerto Rican
2161-8	Salvadoran
2155-0	Central American (not otherwise specified)
2165-9	South American (not otherwise specified)
2060-2	African
2058-6	African American
AMERCN	American
2028-9	Asian
2029-7	Asian Indian
BRAZIL	Brazilian
2033-9	Cambodian
CVERDN	Cape Verdean
CARIBI	Caribbean Island
2034-7	Chinese
2169-1	Columbian
2108-9	European
2036-2	Filipino
2157-6	Guatemalan
2071-9	Haitian
2158-4	Honduran
2039-6	Japanese
2040-4	Korean
2041-2	Laotian
2118-8	Middle Eastern
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOW	Unknown/not specified

(g) ME026. This element is named "other ethnicity". The data type of this element is text. Its length is twenty. Carriers shall enter patient ethnicity, if ME024 Ethnicity 1 or ME025 Ethnicity 2 is coded as OTHER Other Ethnicity.

(h) ME027. This element is named "record type". The data type of this element is text. Its length is 2. Its value is literally "ME".

b. The specifications for the member eligibility file shall be submitted using the following:

Table 7 Member Eligibility File Layout

Data Element #	Element	Type	Max. Length	Description/Codes/Sources
ME001	Payer	Text	6	Payer submitting payments
				Council Submitter Code
ME002	National Plan ID	Text	30	CMS National Plan ID
ME003	Insurance Type Code/Product	Text	2	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
				13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12-month coordination period with an Employer Group Health Plan
				14 Medicare Secondary, No-fault insurance including insurance in which auto is primary
				15 Medicare Secondary Workers' Compensation
				16 Medicare Secondary Public Health Service or Other Federal Agency
				41 Medicare Secondary Black Lung
				42 Medicare Secondary Veterans Administration
				43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
				47 Medicare Secondary, Other Liability Insurance is Primary
				AP Auto Insurance Policy
				CP Medicare Conditionally Primary
				D Disability
				DB Disability Benefits
				EP Exclusive Provider Organization
				HM Health Maintenance Organization (HMO)
				HN Health Maintenance Organization (HMO) Medicare Risk
				HS Special Low Income Medicare

				Beneficiary
				IN Indemnity
				LC Long Term Care
				LD Long Term Policy
				LI Life Insurance
				LT Litigation
				MA Medicare Part A
				MB Medicare Part B
				MC Medicaid
				MH Medigap Part A
				MI Medigap Part B
				MP Medicare Primary
				PR Preferred Provider Organization (PPO)
				PS Point of Service (POS)
				QM Qualified Medicare Beneficiary
				SP Supplemental Policy
				WC Workers' Compensation
ME004	Year	Integer	4	Year for which eligibility is reported in this submission
ME005	Month	Integer	2	Month for which eligibility is reported in this submission
ME006	Insured Group or Policy Number	Text	30	Group or policy number (not the number that uniquely identifies the subscriber)
ME007	Coverage Level Code	Text	3	Benefit Coverage Level
				CHD Children Only
				DEP Dependents Only
				ECH Employee and Children
				EMP Employee Only
				ESP Employee and Spouse
				FAM Family
				IND Individual
				SPC Spouse and Children
				SPO Spouse Only
ME008	Encrypted Subscriber Unique Identification Number	Text	30	Encrypted subscriber's unique identification number (*set as null if unavailable*)
ME009	Plan Specific Contract Number	Text	30	Encrypted plan assigned contract number (*set as null if contract number = subscriber's social security* number)

ME010	Member Suffice or Sequence Number	Integer	2	Uniquely numbers the member within the contract
ME011	Member Identification Code	Text	30	Encrypted member's unique identification number (*set as null if unavailable*)
ME012	Individual Relationship Code	Integer	2	Member's relationship to insured
				01 Spouse
				18 Self/Employee
				19 Child
				21 Unknown
				34 Other Adult
ME013	Member Gender	Text	1	M Male
				F Female
				U Unknown
ME014	Member Date of Birth	Date	8	CCYYMMDD
ME015	Member City Name	Text	30	City name of member
ME016	Member State or Province	Text	2	As defined by the US Postal Service
ME017	Member ZIP Code	Text	11	ZIP Code of member – may include non-US codes. (Do not include dash)
ME018	Medical Coverage	Text	1	Y Yes
				N No
ME019	Prescription Drug Coverage	Text	1	Y Yes
				N No
ME020	Race 1	Text	6	R1 American Indian/Alaska Native
				R2 Asian
				R3 Black/African American
				R4 Native Hawaiian or other Pacific Islander
				R5 White
				R9 Other Race
				UNKNOW Unknown/not specified
ME021	Race 2	Text	6	R1 American Indian/Alaska Native
				R2 Asian
				R3 Black/African American
				R4 Native Hawaiian or other Pacific

				Islander
				R5 White
				R9 Other Race
				UNKNOW Unknown/not specified
ME022	Other Race	Text	15	Patient Race, if Race 1 or Race 2 is entered as R9 Other Race *(set as null if none)*
ME023	Hispanic Indicator	Text	1	Y Patient is Hispanic/Latino/Spanish.
				N Patient is not Hispanic/Latino/Spanish.
				U Unknown
ME024	Ethnicity 1	Text	6	2182-4 Cuban 2184-0 Dominican 2148-5 Mexican, Mexican American, Chicano 2180-8 Puerto Rican 2161-8 Salvadoran 2155-0 Central American (not otherwise specified) 2165-9 South American (not otherwise specified) 2060-2 African 2058-6 African American AMERCN American 2028-9 Asian 2029-7 Asian Indian BRAZIL Brazilian 2033-9 Cambodian CVERDN Cape Verdean CARIBI Caribbean Island 2034-7 Chinese 2169-1 Columbian 2108-9 European 2036-2 Filipino 2157-6 Guatemalan 2071-9 Haitian 2158-4 Honduran 2039-6 Japanese 2040-4 Korean 2041-2 Laotian 2118-8 Middle Eastern

				PORTUG	Portuguese
				RUSSIA	Russian
				EASTEU	Eastern European
				2047-9	Vietnamese
				OTHER	Other Ethnicity
				UNKNOW	Unknown/not specified
ME025	Ethnicity 2	Text	6	2182-4	Cuban
				2184-0	Dominican
				2148-5	Mexican, Mexican American, Chicano
				2180-8	Puerto Rican
				2161-8	Salvadoran
				2155-0	Central American (not otherwise specified)
				2165-9	South American (not otherwise specified)
				2060-2	African
				2058-6	African American
				AMERCN	American
				2028-9	Asian
				2029-7	Asian Indian
				BRAZIL	Brazilian
				2033-9	Cambodian
				CVERDN	Cape Verdean
				CARIBI	Caribbean Island
				2034-7	Chinese
				2169-1	Columbian
				2108-9	European
				2036-2	Filipino
				2157-6	Guatemalan
				2071-9	Haitian
				2158-4	Honduran
				2039-6	Japanese
				2040-4	Korean
				2041-2	Laotian
				2118-8	Middle Eastern
				PORTUG	Portuguese
				RUSSIA	Russian
				EASTEU	Eastern European
				2047-9	Vietnamese

				OTHER Other Ethnicity UNKNOW Unknown/not specified
ME026	Other Ethnicity	Text	20	Patient Ethnicity if Ethnicity 1 or Ethnicity 2 is entered as OTHER Other Ethnicity. *(set as null if none)*
ME027	Record Type	Text	2	ME

c. The member eligibility file shall be mapped to a national standard format that conforms to the following:

Table 8 Member Eligibility File Mapping

Data Element #	**Element**	**HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/ Data Element**
ME001	Payer	N/A
ME002	National Plan ID	271/2100A/NM1/XV/09
ME003	Insurance Type Code/Product	271/2110C/EB/ /04, 271/2110D/EB/ /04
ME004	Year	N/A
ME005	Month	N/A
ME006	Insured Group or Policy Number	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
ME007	Coverage Level Code	271/2110C/EB/ /03, 271/2100D/EB/ /03
ME008	Encrypted Subscriber Unique Identification Number	271/2100C/NM1/MI/09
ME009	Plan Specific Contract Number	271/2100C/NM1/MI/09
ME010	Member Suffix or Sequence Number	N/A
ME011	Member Identification Code	271/2100C/MN1/MI/09, 271/2100D/NM1/MI/09
ME012	Individual Relationship Code	271/2100C/INS/Y/02, 271/2100D/INS/N/02
ME013	Member Gender	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
ME015	Member City Name	271/2100C/N4/ /01, 271/2100D/N4/ /01
ME016	Member State or Province	217/2100C/N4/ /02, 271/2100D/N4/ /02
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A
ME019	Prescription Drug Coverage	N/A
ME020	Race 1	N/A
ME021	Race 2	N/A
ME022	Other Race	N/A
ME023	Hispanic Indicator	N/A
ME024	Ethnicity 1	N/A
ME025	Ethnicity 2	N/A

ME026	Other Ethnicity	N/A
ME027	Record Type	N/A

D. MEDICAL CLAIM FILE

a. Medical claim file shall be submitted using the following data elements:

1. MC001. This element is named "payer". The data type of this element is text. Its length is 6. Carriers shall code according to the payer submitting payments, Council submitter code.
2. MC002. This element is named "national plan ID". The data type of this element is text. Its length is 30. Carriers shall code according to the CMS national plan ID.
3. MC003. This element is named "insurance type/product code". The data type of this element is text. Its length is 2. Carriers shall code according to the following:

Table 9 Insurance Type/Product Code

Code	**Description**
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
DS	Disability
HM	Health Maintenance Organization
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
VA	Veterans Administration Plan
WC	Workers' Compensation

4. MC004. This element is named "payer claim control number". The data type of this element is text. Its length is 35. Carriers shall code according to the entire claim and be unique within the payer's system.
5. MC005. This element is named "line counter". The data type of this element is integer. Its length is 4. Carriers shall code according to line number for this service. The line counter shall begin with one and shall be incremented by one for each additional line of a claim.
6. MC005A. This element is named "version number". The data type of this element is integer. Its length is 4. Carriers shall code according to version number of this claim service line. The version number begins with zero, and is incremented by one for each subsequent version of that service line.
7. MC006. This element is named "insured group or policy number". The data type of this element is text. Its length is 30. Carriers shall code according to the group or policy number, not the number that uniquely identifies the subscriber.
8. MC007. This element is named "encrypted subscriber unique identification number". The data type of this element is text. Its length is 30. Carriers shall code according to the encryption method developed by the Council or its designee. Carriers shall set as null if unavailable.
9. MC008. This element is named "plan specific contract number". The data type of this element is text. Its length is 30. Carriers shall code according to the encrypted plan assigned contract number. Carriers shall set as null if the contract number is the same as the subscriber's social security number.
10. MC009. This element is named "member suffix or sequence number". The data type of this element is integer. Its length is 2. Carriers shall code according to the unique number of the member within the contract.
11. MC010. This element is named "member identification code". The data type of this element is text. Its length is 30. Carriers shall code according to the encryption method developed by the Council or its designee. Carriers shall set as null if unavailable.

12. MC011. This element is named "individual relationship code". The data type of this element is integer. Its length is 2. Carriers shall code according to member's relationship to subscriber shown as follows:

Table 10 Individual Relationship Code

Code	**Description**
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employer
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Where Insured Has No Financial Responsibility

53	Life Partner
76	Dependent

13. MC012. This element is named "member gender". The data type of this element is text. Its length is one. Carriers shall code according to:

(i) M Male;

(ii) F Female; and

(iii) U Unknown.

14. MC013. This element is named "member date of birth". The data type of this element is date. Its length is 8. Carriers shall code according to CCYYMMDD.

15. MC014. This element is named "member city name". The data type of this element is text. Its length is 30. Carriers shall code according to the city name of the member's residence.

16. MC015. This element is named "member state or province". The data type of this element is text. Its length is 2. Carriers shall code the state in which the member resides using the standard abbreviations established by the U.S. Postal Service.

17. MC016. This element is named "member ZIP code". The data type of this element is text. Its length is 11. Carriers shall code according to ZIP Code of member's residence. This may include non-US codes. Carriers and health care claims processors shall not use the dash in coding.

18. MC017. This element is named "date service approved" (AP Date). This field is designed to capture the paid date, also called the Accounts Payable date. The data type of this element is date. Its length is 8. Carriers shall code this date in CCYYMMDD format.

19. MC018. This element is named "admission date". The data type of this element is date. Its length is 12. Carriers shall code for all inpatient claims using CCYYMMDD.

20. MC019. This element is named "admission hour". The data type of this element is integer. Its length is 4. Carriers shall code for all inpatient claims, and shall express time in military time, and may report the hour as HH or as HHMM.

21. MC020. This element is named "admission type". The data type of this element is text. Its length is one. Carriers shall code using an integer shown as follows:

Table 11 Admission Type

Code	**Description**
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
9	Information Not Available

22. MC021. This element is named "admission source". The data type of this element is text. Its length is one. Carriers shall code using text shown as follows:

Table 12 Admission Source

Code	Description
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Unknown
A	Transfer from a Rural Primary Care Hospital

23. MC022. This element is named "discharge hour". The data type of this element is integer. Its length is 4. Carriers shall code using military time and may report the hour as HH or as HHMM.

24. MC022A. This element is named "discharge date". The data type of this element is date. Its length is 8. Carriers shall code for all inpatient claims using CCYYMMDD.

24. MC023. This element is named “discharge status". The data type of this element is integer. Its length is 2. Carriers shall code shown as follows:

Table 13 Discharge Status

Code	Description
01	Discharged to home or self care
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to nursing facility (NF)
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to this hospital
20	Expired
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility

42	Expired, place unknown
43	Discharged/transferred to a Federal Hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

25. MC024. This element is named "service provider number". The data type of this element is text. Its length is 30. Carriers shall code using the payer assigned provider number.
26. MC025. This element is named "service provider tax ID number". The data type of this element is text. Its length is 10. Carriers shall code using the federal taxpayer's identification number.
27. MC026. This element is named "national service provider ID". The data type of this element is text. Its length is 20. Carriers shall code if national provider ID is mandated for use under HIPAA.
28. MC027. This element is named "service provider entity type qualifier". The data type of this element is text. Its length is one. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person", and these shall be coded as a person. Carriers shall code according to:

(i) 1 = Person; and
(ii) 2 = Non-person entity

29. MC028. This element is named "service provider first name". The data type of this element is text. Its length is 25. Carriers shall code according to the individual's first name, and set to null if the provider is a facility or organization.
30. MC029. This element is named "service provider middle name". The data type of this element is text. Its length is 25. Carriers shall code according to the entity's middle name or initial, and shall set to null if provider is a facility or organization.
31. MC030. This element is named "service provider last name or organization name". The data type of this element is text. Its length is 50. Carriers shall code using the full name of the provider organization or last name of individual provider.

32. MC031. This element is named "service provider suffix". The data type of this element is text. Its length is 10. Carriers shall code according to the suffix to the individual name, and set to null if the provider is a facility or organization. The service provider suffix shall be used to capture the generation of individual clinician (e.g., Jr., Sr., III.), if applicable, rather than the clinician's degree (e.g., MD, LICSW).
33. MC032. This element is named "service provider specialty". The data type of this element is text. Its length is 10. Carriers shall code as defined by the payer dictionary for specialty code value, which shall be supplied during testing.
34. MC033. This element is named "service provider city name". The data type of this element is text. Its length is 30. Carriers shall code according to the city name of provider, and preferably the practice location.
35. MC034. This element is named "service provider state". The data type of this element is text. Its length is 2. Carriers shall code as defined by the US Postal Service.
36. MC035. This element is named "service provider ZIP Code". The data type of this element is text. The length is 11. Carriers shall code according to ZIP code of provider, which may include non-US codes. Carriers shall not use the dash in coding.
MC035A. This element is named "service provider country name". The data type of this element is text. Its length is 30. Carriers shall code according to the country name of provider, and preferably the practice location.

37. MC036. This element is named "type of bill on Facility Claims". The data type of this element is integer. Its length is 2. Carriers shall use this coding on facility claims, including those submitted using UB92 forms, shown as follows:

Table 14 Type of Bill on Facility Claims

First Digit	**Type of Facility**
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
5	Christian Science Extended Care
6	Intermediate Care
7	Clinic
8	Special Facility
Second Digit if First Digit = 1 through 6	**Bill Classification**
1	Inpatient (including Medicare Part A)
2	Inpatient (including Medicare Part B Only)
3	Outpatient
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Nursing Facility Level I
6	Nursing Facility Level II
7	Intermediate Care – Level III Nursing Facility
8	Swing Beds
Second Digit if First Digit = 7	**Bill Classification**
1	Rural Health
2	Hospital Based or Independent Renal
3	Dialysis Center
4	Free Standing
5	Outpatient Rehabilitation Facility (ORF)
6	Comprehensive Outpatient Rehabilitation
7	Facilities (CORFs)
9	Other
Second Digit if First Digit = 8	**Bill Classification**
1	Hospice, Non-hospital based
2	Hospital, Hospital based

3	Ambulatory Surgery Center
4	Free Standing Birthing Center
9	Other

38. MC037. This element is named "site of service on NSF/CMS 1500 claims". The data type of this element is text. Its length is 2. Carriers shall use this coding on professional claims, including those submitted using NSF CMS 1500 forms, shown as follows:

Table 15 Site of Service on NSF/CMS 1500 Claims

Code	**Facility**
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance –Air or Water
50	Federally Qualified Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State of Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

39. MC038. This element is named "claim status". The data type of this element is integer. Its length is 2. This code describes the payment status of the specific service line record. Carriers shall code according to the following:

(i) 01 Processed as primary;
(ii) 02 Processed as secondary;
(iii) 03 Processed as tertiary;
(iv) 04 Denied;
(v) 19 Processed as primary, forwarded to additional payer(s);
(vi) 20 Processed as secondary, forwarded to additional payer(s);
(vii) 21 Processed as tertiary, forwarded to additional payer(s); and
(viii) 22 Reversal of previous payment.

40. MC039. This element is named "admitting diagnosis". The data type of this element is text. Its length is 5. Carriers shall code according to all inpatient admission claims and encounters using the ICD-9-CM without the decimal point.
41. MC040. This element is named "E-code". The data type of this element is text. Its length is 5. Carriers shall use this code to describe an injury, poisoning or adverse effect, ICD-9-CM without coding decimal points.
42. MC041. This element is named "principal diagnosis". The data type of this element is text. Its length is 5. Carriers shall code the principal diagnosis given on the claim header using CD-9-CM without coding decimal points.
43. MC042. This element is named "other diagnosis – 1". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
44. MC043. This element is named "other diagnosis – 2". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
45. MC044. This element is named "other diagnosis – 3". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
46. MC045. This element is named "other diagnosis – 4". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
47. MC046. This element is named "other diagnosis – 5". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
48. MC047. This element is named "other diagnosis – 6". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
49. MC048. This element is named "other diagnosis – 7". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
50. MC049. This element is named "other diagnosis – 8". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
51. MC050. This element is named "other diagnosis – 9". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.

52. MC051. This element is named "other diagnosis – 10". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
53. MC052. This element is named "other diagnosis – 11". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
54. MC053. This element is named "other diagnosis – 12". The data type of this element is text. Its length is 5. Carriers shall code using ICD-9-CM without coding decimal points.
55. MC054. This element is named "revenue code". The data type of this element is text. Its length is 4. Carriers shall code using national uniform billing committee codes. Carriers shall code using leading zeroes, left-justified, and four digits.
56. MC055. This element is named "procedure code". The data type of this element is text. Its length is 5. Carriers shall code according to the Health Care Common Procedural Coding System (HCPCS). This includes the CPT codes of the American Medical Association.
57. MC056. This element is named "procedure modifier – 1". The data type of this element is text. Its length is 2. Carriers shall code using a procedure modifier when a modifier clarifies or improves the reporting accuracy of the associated procedure code.
58. MC057. This element is named "procedure modifier – 2". The data type of this element is text. Its length is 2. Carriers shall code using a procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.
59. MC058. This element is named "ICD-9-CM procedure code". The data type of this element is text. Its length is 4. Carriers shall code using the primary ICD-9-CM code given on the claim header without coding decimal points.

60. MC059. This element is named "date of service – from". The data type of this element is date. Its length is 8. Carriers shall code using the first date of service for this service line, CCYYMMDD.
61. MC060. This element is named "date of service – thru". The data type of this element is date. Its length is 8. Carriers shall code using the last date of service for this service line, CCYYMMDD.
62. MC061. This element is named "quantity". The data type of this element is integer. Its length is 3. Carriers shall code according to the count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.
63. MC062. This element is named "charge amount". The data type of this element is decimal. Its length is 10. Carriers shall code according to the charge without coding decimal points.
64. MC063. This element is named "paid amount". The data type of this element is decimal. Its length is 10. Carriers shall code including withhold amounts without coding decimal points.

65. MC064. This element is named "prepaid amount". The data type of this element is decimal. Its length is 10. Carriers shall code using for capitated services, the fee for service equivalent amount without coding decimal points.

66. MC065. This element is named "co-pay amount". The data type of this element is decimal. Its length is 10. Carriers shall code using the preset, fixed dollar amount for which the individual is responsible without coding decimal points.
67. MC066. This element is named "coinsurance amount". The data type of this element is decimal. Its length is 10. Carriers shall code using the dollar amount of the coinsurance without coding decimal points.
68. MC067. This element is named "deductible amount". The data type of this element is decimal. Its length is 10. Carriers shall code using the dollar amount of the deductible without coding decimal points.
69. MC068. This element is named "record type". The data type of this element is text. Its length is 2.

b. The file specification for the medical claim file shall conform to the following:

Table 16 Medical Claims File Layout

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
MC001	**Payer**	Text	6	Payer submitting payments
				Council Submitter Code
MC002	**National Plan ID**	Text	30	CMS National Plan ID
MC003	**Insurance Type/Product Code**	Text	2	12 Preferred Provider Organization (PPO)
				13 Point of Service (POS)
				14 Exclusive Provider Organization (EPO)
				15 Indemnity Insurance
				16 Health Maintenance Organization (HMO) Medicare Risk
				DS Disability
				HM Health Maintenance Organization
				MA Medicare Part A
				MB Medicare Part B
				MC Medicaid
				VA Veteran Administration Plan
				WC Worker's Compensation
MC004	**Payer Claim Control Number**	Text	35	Must apply to the entire claim and be unique within the payer's system
MC005	**Line Counter**	Integer	4	Line number for this service
				The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
MC005A	**Version Number**	Integer	4	Version number of this claim service line
				The version number begins with 0 and is incremented by 1 for each subsequent version of that service line
MC006	**Insured Group or Policy Number**	Text	30	Group or policy number (not the number that uniquely identifies the subscriber)

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
MC007	**Encrypted Subscriber Unique Identification Number**	Text	30	Encrypted subscriber's Unique Identification number *Set as null if unavailable*
MC008	**Plan Specific Contract Number**	Text	30	Encrypted plan assigned *Set as null if contract number = subscriber's social security number*
MC009	**Member Suffix or Sequence Number**	Integer	2	Uniquely numbers the member within the contract
MC010	**Member Identification Code**	Text	30	Encrypted member's Unique Identification number Set as null if unavailable
MC011	**Individual Relationship Code**	Integer	2	Member's relationship to subscriber
				01 Spouse
				04 Grandfather or Grandmother
				05 Grandson or Granddaughter
				07 Nephew or Niece
				10 Foster Child
				15 Ward
				17 Stepson or Stepdaughter
				19 Child
				20 Employee
				21 Unknown
				22 Handicapped Dependent
				23 Sponsored Dependent
				24 Dependent of a Minor Dependent
				29 Significant Other
				32 Mother
				33 Father
				36 Emancipated Minor
				39 Organ Donor
				40 Cadaver Donor
				41 Injured Plaintiff
				43 Where Insured Has No Financial Responsibility
				53 Life Partner
				76 Dependent
MC012	**Member Gender**	Text	1	M Male
				F Female
				U Unknown
MC013	**Member Date of Birth**	Date	8	CCYYMMDD
MC014	**Member City Name**	Text	30	City name of member

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
MC015	**Member State or Province**	Text	2	As defined by the US Postal Service
MC016	**Member ZIP Code**	Text	11	ZIP Code of member - may include non-US codes
MC017	**Date Service Approved (AP Date)**	Date	8	CCYYMMDD
				(Generally the same as the paid date)
MC018	**Admission Date**	Date	8	Required for all inpatient claims
				CCYYMMDD
MC019	**Admission Hour**	Integer	4	Required for all inpatient claims
				Time is expressed in military time – HH or HHMM
MC020	**Admission Type**	Integer	1	
MC021	**Admission Source**	Text	1	
MC022	**Discharge Hour**	Integer	4	Hour in military time – HH or HHMM
MC022A	**Discharge Date**	Date	8	Required for all inpatient claims CCYYMMDD
MC023	**Discharge Status**	Integer	2	01 Discharged to home or self care
				02 Discharged/transferred to another short-term general hospital for inpatient care
				03 Discharged/transferred to skilled nursing facility (SNF)
				04 Discharged/transferred to nursing facility (NF)
				05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
				06 Discharged/transferred to home under care of organized home health service organization
				07 Left against medical advice or discontinued care
				08 Discharged/transferred to home under care of a Home IV provider
				09 Admitted as an inpatient to this hospital
				20 Expired
				30 Still patient or expected to return for outpatient services
MC024	**Service Provider Number**	Text	30	Payer assigned provider number

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
MC025	**Service Provider Tax ID Number**	Text	10	Federal taxpayer's identification number
MC026	**National Service Provider ID**	Text	20	Required if National Provider ID is mandated for use under HIPAA
MC027	**Service Provider Entity Type Qualifier**	Text	1	1 Person 2 Non-Person Entity
				HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as “Person”.
MC028	**Service Provider First Name**	Text	25	Individual first name
				Set to null if provider is a facility or organization
MC029	**Service Provider Middle Name**	Text	25	Individual middle name or initial
				Set to null if provider is a facility or organization
MC030	**Service Provider Last Name or Organization Name**	Text	50	Full name of provider organization or last name of individual provider
MC031	**Service Provider Suffix**	Text	10	Suffix to individual name
				Set to null if provider is a facility or organization. Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than the clinician’s degree [e.g., ‘MD’, ‘LICSW’].
MC032	**Service Provider Specialty**	Text	10	As defined by payer
				Dictionary for specialty code values must be supplied during testing
MC033	**Service Provider City Name**	Text	30	City name of provider - preferably practice location
MC034	**Service Provider State**	Text	2	As defined by the US Postal Service
MC035	**Service Provider ZIP Code**	Text	11	ZIP Code of provider - may include non-US codes Do not include dash

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
MC035A	**Service Provider Country Name**	Text	30	Country name of provider - preferably practice location
MC036	**Type of Bill – on Facility Claims**	Integer	2	**Type of Facility - First Digit**
	(Should be coded on facility claims, such as those submitted using on UB92 forms)			1 Hospital
				2 Skilled Nursing
				3 Home Health
				4 Christian Science Hospital
				5 Christian Science Extended Care
				6 Intermediate Care
				7 Clinic
				8 Special Facility
				Bill Classification - Second Digit if First Digit = 1-6
				1 Inpatient (Including Medicare Part A)
				2 Inpatient (Medicare Part B Only)
				3 Outpatient
				4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
				5 Nursing Facility Level I
				6 Nursing Facility Level II
				7 Intermediate Care - Level III Nursing Facility
				8 Swing Beds
				Bill Classification - Second Digit if First Digit = 7
				1 Rural Health
				2 Hospital Based or Independent Renal
				3 Dialysis Center
				4 Free Standing
				5 Outpatient Rehabilitation Facility (ORF)
				6 Comprehensive Outpatient Rehabilitation
				7 Facilities (CORFs)
				9 Other
				Bill Classification – Second Digit if First Digit = 8
				1 Hospice (Non Hospital Based)
				2 Hospice (Hospital-Based)
				3 Ambulatory Surgery Center
				4 Free Standing Birthing Center

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				9 Other
MC037	**Site of Service – on NSF/CMS 1500 Claims**	Text	2	11 Office
	(Should be coded on professional claims, such as those submitted using NSF [CMS 1500 forms])			12 Home
				21 Inpatient Hospital
				22 Outpatient Hospital
				23 Emergency Room – Hospital
				24 Ambulatory Surgery Center
				25 Birthing Center
				26 Military Treatment Facility
				31 Skilled Nursing Facility
				32 Nursing Facility
				33 Custodial Care Facility
				34 Hospice
				41 Ambulance – Land
				42 Ambulance – Air or Water
				51 Inpatient Psychiatric Facility
				52 Psychiatric Facility Partial Hospitalization
				53 Community Mental Health Center
				54 Intermediate Care Facility/Mentally Retarded
				55 Residential Substance Abuse Treatment Facility
				56 Psychiatric Residential Treatment Center
				50 Federally Qualified Center
				60 Mass Immunization Center
				61 Comprehensive Inpatient Rehabilitation Facility
				62 Comprehensive Outpatient Rehabilitation Facility
				65 End Stage Renal Disease Treatment Facility
				71 State of Local Public Health Clinic
				72 Rural Health Clinic
				81 Independent Laboratory
				99 Other Unlisted Facility
MC038	**Claim Status**	Integer	2	01 Processed as primary
	(Actually describes the payment status of the specific service line record)			02 Processed as secondary
				03 Processed as tertiary

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				04 Denied
				19 Processed as primary, forwarded to additional payer(s)
				20 Processed as secondary, forwarded to additional payer(s)
				21 Processed as tertiary, forwarded to additional payer(s)
				22 Reversal of previous payment
MC039	**Admitting Diagnosis**	Text	5	Required on all inpatient admission claims and encounters
				ICD-9-CM Do not code decimal point
MC040	**E-Code**	Text	5	Describes an injury, poisoning or adverse effect
				ICD-9-CM Do not include decimal
MC041	**Principal Diagnosis**	Text	5	ICD-9-CM Do not code decimal point
	This should be the principal diagnosis given on the claim header.			
MC042	**Other Diagnosis – 1**	Text	5	ICD-9-CM Do not code decimal point
MC043	**Other Diagnosis – 2**	Text	5	ICD-9-CM Do not code decimal point
MC044	**Other Diagnosis – 3**	Text	5	ICD-9-CM Do not code decimal point
MC045	**Other Diagnosis – 4**	Text	5	ICD-9-CM Do not code decimal point
MC046	**Other Diagnosis – 5**	Text	5	ICD-9-CM Do not code decimal point
MC047	**Other Diagnosis – 6**	Text	5	ICD-9-CM Do not code decimal point
MC048	**Other Diagnosis – 7**	Text	5	ICD-9-CM Do not code decimal point
MC049	**Other Diagnosis – 8**	Text	5	ICD-9-CM Do not code decimal point
MC050	**Other Diagnosis – 9**	Text	5	ICD-9-CM Do not code decimal point
MC051	**Other Diagnosis – 10**	Text	5	ICD-9-CM Do not code decimal point
MC052	**Other Diagnosis – 11**	Text	5	ICD-9-CM Do not code decimal point
MC053	**Other Diagnosis – 12**	Text	5	ICD-9-CM Do not code decimal point
MC054	**Revenue Code**	Text	4	National Uniform Billing Committee Codes

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
				Code using leading zeroes, left-justified, and four digits.
MC055	**Procedure 1 Code**	Text	5	Health Care Common Procedural Coding System (HCPCS)
				This includes the CPT codes of the American Medical Association
MC056	**Procedure 1 Modifier – 1**	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC057	**Procedure 1 Modifier – 2**	Text	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code
MC058	**ICD-9-CM Procedure 1 Code**	Text	4	Primary ICD-9-CM code given on the claim header. Do not code decimal point
MC059	**Date of Service – From**	Date	8	First date of service for this service line
				CCYYMMDD
MC060	**Date of Service – Thru**	Date	8	Last date of service for this service line
				CCYYMMDD
MC061	**Quantity**	Integer	3	Count of services performed
				Should be set equal to 1 on all Observation bed service lines, for consistency.
MC062	**Charge Amount**	Decimal	10	Do not code decimal point
MC063	**Paid Amount**	Decimal	10	Includes any withhold amounts
				Do not code decimal point
MC064	**Prepaid Amount**	Decimal	10	For capitated services, the fee for service equivalent amount
				Do not code decimal point
MC065	**Copay Amount**	Decimal	10	The preset, fixed dollar amount for which the individual is responsible Do not code decimal point
MC066	**Coinsurance Amount**	Decimal	10	Do not code decimal point

Data Element #	Data Element Name	Type	Maximum Length	Description/Codes/Sources
MC067	**Deductible Amount**	Decimal	10	Do not code decimal point
MC068	**Record Type**	Text	2	MC

c. The mapping for medical claims file shall conform to the following national standard:

Table 17 Medical Claims File Mapping

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
MC001	Payer	N/A	N/A	N/A	N/A	N/A
MC002	National Plan ID	N/A	N/A	N/A	N/A	835/1000A/N1/XV/04
MC003	Product/Claim Filing Indicator Code	N/A	30/4	N/A	N/A	835/2100/CLP/ /06
MC004	Payer Claim Control Number	N/A	N/A	N/A	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0	835/2100/CLP/ /07
MC005	Line Counter	N/A	N/A	N/A	N/A	837/2400/LX/ /01
MC006	Insured Group or Policy Number	62 (A-C)	30/10	11C	DA0-10.0	837/2000B/SBR/ /03
MC007	Encrypted Subscriber Unique Identification Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC008	Plan Specific Contract Number	N/A	N/A	N/A	N/A	835/2100/NM1/HN/08
MC009	Member Suffix or Sequence Number	N/A	N/A	N/A	N/A	N/A
MC010	Member Identification Code	N/A	N/A	N/A	N/A	835/2100/NM1/34/08
MC011	Individual Relationship Code	59 (A-C)	30/18	6	DA0-17.0	8 837/2000B/SBR/ /02, 837/2000C/PAT/ /01
MC012	Member Gender	15	20/7	3	CA0-09.0	837/2010CA/DMG/03
MC013	Member Date of Birth	14	20/8	3	CA0-08.0	837/2010CA/DMG/D8/02

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
MC014	Member City Name	13	20/14	5	CA0-13.0	837/2010CA/N4/ /01
MC015	Member State or Province	13	20/15	5	CA0-14.0	837/2010CA/N4/ /02
MC016	Member ZIP Code	13	20/16	5	CA0-15.0	837/2010CA/N4/ /03
MC017	Date Service Approved	N/A	N/A	N/A	N/A	N/A
MC018	Admission Date	17	20/17	N/A	N/A	837/2300/DTP/435/03
MC019	Admission Hour	18	20/18	N/A	N/A	837/2300/DTP/435/03
MC020	Admission Type	19	20/10	N/A	N/A	837/2300/CL1/ /01
MC021	Admission Source	20	20/11		N/A	837/2300/CL1/ /02
MC022	Discharge Hour	21	20/22		N/A	837/2300/DTP/096/03
MC023	Discharge Status	22	20/21	N/A	N/A	837/2300/CL1/ /03
MC024	Service Provider Number	N/A	N/A	N/A	N/A	N/A
MC025	Service Provider Tax ID Number	5	10/4-5	25	BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0,BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0,BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0	835/2100/NM1/FI/09
MC026	National Service Provider ID	N/A	10/6	N/A	N/A	835/2100/NM1/XX/09
MC027	Service Provider Entity Type Qualifier	N/A	N/A	N/A	N/A	835/2100/NM1/82/02
MC028	Service Provider First Name	1	10/12	33	BA0-20.0	835/2100/NM1/82/04
MC029	Service Provider Middle Name	1	10/12	33	BA0-21.0	835/2100/NM1/82/05
MC030	Service Provider Last Name or Organization Name	1	10/12	33	BA0-18.0, BA0-19.0	835/2100/NM1/82/03
MC031	Service Provider Suffix	1	10/12	33	BA0-22.0	835/2100/NM1/82/07

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
MC032	Service Provider Specialty	N/A	N/A	N/A	N/A	837/2000A/PRV/ZZ/03
MC033	Service Provider City Name	1	10/14	N/A	BA1-09.0, 15.0	837/2010A/N4/ /01
MC034	Service Provider State or Province	1	10/15	N/A	BA1-10.0, 16.0	837/2010A/N4/ /02
MC035	Service Provider ZIP Code	1	10/16	N/A	BA1-11.0, 17.0	837/2010A/N4/ /03
MC036	Type of Bill – on Facility Claims	4	Positions 1-2: 40/4	N/A	N/A	837/2300/CLM/ /05-1
MC037	Site of Service – on NSF/CMS 1500 Claims	N/A	N/A	N/A	FA0-07.0, GU0-0.50	835/2100/CLP/ /08
MC038	Claim Status	N/A	N/A	N/A	N/A	835/2100/CLP/ /02
MC039	Admitting Diagnosis	76	70/25	N/A	N/A	837/2300/HI/BJ/02-2
MC040	E-Code	77	70/26	N/A	N/A	837/2300/HI/BN/03-2
MC041	Principal Diagnosis	67	70/4	21.1	EA0-32.0, GX0-31.0, GU0-12.0	837/2300/HI/BK/01-2
MC042	Other Diagnosis – 1	68	70/5	21.2	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-1
MC043	Other Diagnosis – 2	69	70/6	21.3	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-2
MC044	Other Diagnosis – 3	70	70/7	21.4	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-3
MC045	Other Diagnosis – 4	71	70/8	N/A	EA0-35.0, GX0-34.0, GU0-15.0	837/2300/HI/BF/02-4
MC046	Other Diagnosis – 5	72	70/9	N/A	N/A	837/2300/HI/BF/02-5
MC047	Other Diagnosis – 6	73	70/10	N/A	N/A	837/2300/HI/BF/02-6
MC048	Other Diagnosis – 7	74	70/11	N/A	N/A	837/2300/HI/BF/02-7
MC049	Other Diagnosis – 8	75	70/12	N/A	N/A	837/2300/HI/BF/02-8
MC050	Other Diagnosis – 9	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-9
MC051	Other Diagnosis –10	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-10
MC052	Other Diagnosis –11	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-11

		UB-92 Form	UB-92 (Version 6.0) Record Type/	HCFA 1500	NSF (National Standard Format)	HIPAA Reference Transaction Set/Loop/ Segment/Qualifier/
Data Element #	**Data Element Name**	**Locator**	**Field #**	**#**	**Locator**	**Data Element**
MC053	Other Diagnosis –12	N/A	N/A	N/A	N/A	837/2300/HI/BF/02-12
MC054	Revenue Code	42	50/5,11-13, 60/5,15-16, 61/5,15-16	N/A	N/A	835/2110/SVC/RB/01-2, 835/2110/SVC/NU/01-2
MC055	Procedure Code	44	60/6,15-16, 61/6,15-16	24.1-6 D	FA0-09.0, FB0-15.0, GU0-07.0	835/2110/SVC/HC/01-2
MC056	Procedure Modifier – 1	44	60/7,15-16, 61/7, 15-16	24.1-6 D	FA0-10.0, GU0-08.0	835/2110/SVC/HC/01-3
MC057	Procedure Modifier – 2	44	60/8,15-16, 61/8,15-16	24.1-6 D	FA0-11.0	835/2110/SVC/HC/01-3
MC058	ICD-9-CM Procedure Code	80, 81(A-E)	70/13, 15, 17, 19, 21, 23	N/A	N/A	835/2110/SVC/ID/01-2
MC059	Date of Service – From	45	61/13, 15-16, 61/13, 15-16	24.1-6 A	N/A	835/2110/DTM/150/02
MC060	Date of Service – Thru	N/A	N/A	24.1-6 A	FA0-05.0, FA0-06.0	835/2110/DTM/151/02
MC061	Quantity	46	50/7, 11-13, 60/9,15-16, 61/9,15-16	24.1-6 G	FA0-19.0, FB0-16.0	835/2110/SVC/ /05
MC062	Charge Amount	47	50/8, 11-13, 60/10, 16-16, 61/11, 15-16	24.1-6F	FA0-13.0	835/2110/SVC/ /02
MC063	Paid Amount	48	N/A	N/A	N/A	835/2110/SVC/ /03
MC064	Prepaid Amount	N/A	N/A	N/A	N/A	N/A
MC065	Co-pay Amount	N/A	N/A	N/A	N/A	N/A
MC066	Coinsurance Amount	N/A	N/A	N/A	N/A	N/A
MC067	Deductible Amount	N/A	N/A	N/A	N/A	N/A
MC068	Record Type	N/A	N/A	N/A	N/A	N/A

E. PHARMACY CLAIMS FILE

a. The pharmacy claim file layout shall be submitted using the following format:

1. PC001. This element is named "payer". The data type of this element is text. Its length is 6. Carriers shall code using the payer submitting payments, Council submitter code.

2. PC002. This element is named "plan ID". The data type of this element is text. Its length is 30. Carriers shall code using the CMS national plan ID.

3. PC003. This element is named "insurance type/product code". The data type of this element is text. Its length is 2. Carriers shall code as follows:

Table 18 Pharmacy Insurance Type/Product Code

Code	**Description**
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Party B
MC	Medicaid
OF	Other Federal Program (e.g. Black Lung)
TV	Title V
VA	Veterans Administration Plan
WC	Workers' Compensation

4. PC004. This element is named "payer claim control number". The data type of this element is text. Its length is 35. Carriers shall code using the entire claim, which shall be unique within the payer's system.
5. PC005. This element is named "line counter". The data type of this element is integer. Its length is 4. Carriers shall code according to line number for this service. The line counter shall begin with one and be incrementally increased by one for each additional service line of a claim.
6. PC006. This element is named "insured group number". The data type of this element is text. Its length is 30. Carriers shall code according to group or policy number and not the number that uniquely identifies the subscriber.
7. PC007. This element is named "encrypted subscriber Unique Identification number". The data type of this element is text. Its length is 30. Carriers shall code

according to the encryption method developed by the Council or its designee. Carriers shall set as null if unavailable.

8. PC008. This element is named "plan specific contract number. The data type of this element is text. Its length is 30. Carriers shall code according to the encrypted plan assigned contract number. Carriers shall set as null if contract number is the same as subscriber's social security number.

9. PC009. This element is named "member suffix or sequence number". The data type of this element is integer. Its length is 2. Carriers shall code according to the unique number that identifies the member within the contract.

10. PC010. This element is named "member identification code". The data type of this element is text. Its length is 30. Carriers shall code according to the encryption method developed by the Council or its designee. Carriers shall set as null if unavailable.

11. PC011. This element is named "individual relationship code". The data type of this element is integer. Its length is 2. Carriers shall code according to member's relationship to subscriber as follows:

Table 19 Individual Relationship Code

Code	**Description**
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employee/Self
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent

12. PC012. This element is named "member gender". The data type of this element is integer. Its length is 1. Carriers shall code as follows:

Table 20 Member Gender

Code	Description
1	Male
2	Female
3	Unknown

13. PC013. This element is named "member date of birth". The data type of this element is date. Its length is 8. Carriers shall code according to CCYYMMDD.
14. PC014. This element is named "member city name of residence. The data type of this element is text. Its length is 30. Carriers shall code according to the city name of member's residence.
15. PC015. This element is named "member state". The data type of this element is text. Its length is 2. Carriers shall code the state in which the member resides using the standard abbreviations established by the US Postal Service.
16. PC016. This element is named "member ZIP code". The data type of this element is text. Its length is 9. Carriers shall code according to the ZIP Code of member's residence, which may include non-US codes. Carriers shall not include dash.
17. PC017. This element is named "date service approved" (AP Date). The data type of this element is date. Its length is 8. Carriers shall code according to CCYYMMDD. This date is generally the same as the paid date or the pharmacy benefits manager's billing date.
18. PC018. This element is named "pharmacy number". The data type of this element is text. Its length is 30. Carriers shall code according to assigned pharmacy number (NCPDP or NABP).
19. PC019. This element is named "pharmacy tax ID number". The data type of this element is text. Its length is 10. Carriers shall code according to Federal taxpayer's identification number. Carriers shall provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.
20. PC020. This element is named "pharmacy name". The data type of this element is text. Its length is 30. Carriers shall code according to the name of pharmacy.
21. PC021. This element is named "national pharmacy ID number. The data type of this element is text. Its length is 20. Carriers shall code according to the national provider ID, if that is mandated for use under HIPAA.
22. PC022. This element is named "pharmacy location city". The data type of this element is text. Its length is 30. Carriers shall code according to the city name of pharmacy.
23. PC023. This element is named "pharmacy location state". The data type of this element is text. Its length is 2. Carriers shall code as defined by the US Postal Service.
24. PC024. This element is named "pharmacy ZIP code". The data type of this element is text. Its length is 10. Carriers shall code according to ZIP code of pharmacy, which may include non-US codes. Carriers shall not include the dash in their codes.

PC024A. This element is named "pharmacy country name". The data type of this element is text. Its length is 30. Carriers shall code according to the country name of pharmacy.

25. PC025. This element is named "claim status". The data type of this element is integer. Its length is 2. Carriers shall code according to:

(i) 01 Processed as primary;
(ii) 02 Processed as secondary;
(iii) 03 Processed as tertiary;
(iv) 04 Denied;
(v) 19 Processed as primary, forwarded to additional payer(s);
(vi) 20 Processed as secondary, forwarded to additional payer(s);
(vii) 21 Processed as tertiary, forwarded to additional payer(s); and
(viii) 22 Reversal of previous payment.

26. PC026. This element is named "drug code". The data type of this element is text. Its length is 11. Carriers shall code according to NDC Code.

27. PC027. This element is named "drug name". The data type of this element is text. Its length is 80. Carriers shall code according to text name of drug.

28. PC028. This element is named "new prescription". The data type of this element is text. Its length is 1. Carriers shall code according to:

(i) N = new prescription; and
(ii) R = refill prescription.

29. PCO28A. This element is named "refill number". The data type of this element is integer. Its length is 2. Carriers shall code according to 01-99 Number of refill. If the refill number is unknown then code as 01.

30. PC029. This element is named "generic drug indicator". The data type of this element is text. Its length is 1. Carriers shall code according to:

(i) N = No, branded drug; and
(ii) Y = Yes, generic drug.

31. PC030. This element is named "dispense as written code". The data type of this element is integer. Its length is one. Carriers shall code according to:

(i) 0 = Not dispensed as written;
(ii) 1 = Physician dispense as written;
(iii) 2 = Member dispense as written;
(iv) 3 = Pharmacy dispense as written;
(v) 4 = No generic available;
(vi) 5 = Brand dispensed as generic;
(vii) 6 = Override;
(viii) 7 = Substitution not allowed, brand drug mandated by law;
(ix) 8 = Substitution allowed, generic drug not available in marketplace; and
(x) 9 = Other.

32. PC031. This element is named "compound drug indicator". The data type of this element is text. Its length is one. Carriers shall code according to:

(i) N = Non-compound drug;
(ii) Y = Compound drug; and
(iii) U = Non-specified drug compound.

33. PC032. This element is named "date prescription filled". The data type of this element is date. Its length is 8. Carriers shall code according to CCYYMMDD.

34. PC033. This element is named "quantity dispensed". The data type of this element is integer. Its length is 5. Carriers shall code according to the number of metric units of medication dispensed.
35. PC034. This element is named "days supply". The data type of this element is integer. Its length is 3. Carriers shall code according to estimated number of days the prescription will last.
36. PC035. This element is named "charge amount". The data type of this element is decimal. Its length is 10. Carriers shall code according to the charge, without coding decimal points.
37. PC036. This element is named "paid amount". The data type of this element is decimal. Its length is 10. Carriers shall code according to "includes all health plan payments and excludes all member payments", without coding decimal points.
38. PC037. This element is named "ingredient cost/list price". The data type of this element is decimal. Its length is 10. Carriers shall code according to Average Wholesale Price (AWP) of the drug dispensed, without coding decimal points.
39. PC038. This element is named "postage amount claimed". The data type of this element is decimal. Its length is 10. Carriers shall not code decimal points.
40. PC039. This element is named "dispensing fee". The data type of this element is decimal. Its length is 10. Carriers shall code according to the fee, without coding decimal points.
41. PC040. This element is named "co-pay amount". The data type of this element is decimal. Its length is 10. Carriers shall code according to the preset, fixed dollar amount for which the individual is responsible, without coding decimal points.
42. PC041. This element is named "coinsurance amount". The data type of this element is decimal. Its length is 10. Carriers shall code not code decimal points.
43. PC042. This element is named "deductible amount". The data type of this element is decimal. Its length is 10. Carriers shall not code decimal points.
44. PC043. This element is named "record type". The data type of this element is text. Its length is 2.

b. The specifications for the pharmacy claims file layout shall conform to the following:

Table 21 Pharmacy Claims File Layout

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
PC001	**Payer**	Text	6	Payer submitting payments
				Council Submitter Code
PC002	**Plan ID**	Text	30	CMS National Plan ID
PC003	**Insurance Type/Product Code**	Text	2	12 Preferred Provider Organization (PPO)
				13 Point of Service (POS)
				14 Exclusive Provider Organization (EPO)
				15 Indemnity Insurance
				16 Health Maintenance Organization (HMO) Medicare Risk
				AM Automobile Medical
				DS Disability
				HM Health Maintenance Organization
				LI Liability
				LM Liability Medical
				MA Medicare Part A
				MB Medicare Part B
				MC Medicaid
				OF Other Federal Program (e.g. Black Lung)
				TV Title V
				VA Veteran Administration Plan
				WC Worker's Compensation
PC004	**Payer Claim Control Number**	Text	35	Must apply to the entire claim and be unique within the payer's system
PC005	**Line Counter**	Integer	4	Line number for this service
				The line counter begins with 1 and is incremented by 1 for each additional service line of a claim
PC006	**Insured Group Number**	Text	30	Group or policy number - not the number that uniquely

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
				identifies the subscriber
PC007	**Encrypted Subscriber Unique Identification Number**	Text	30	Encrypted subscriber's Unique Identification number Set as null if unavailable
PC008	**Plan Specific Contract Number**	Text	30	Encrypted plan assigned contract number
				Set as null if contract number = subscriber's social security number
PC009	**Member Suffix or Sequence Number**	Integer	2	Uniquely numbers the member within the contract
PC010	**Member Identification Code**	Text	30	Encrypted member's Unique Identification number Set as null if unavailable
PC011	**Individual Relationship Code**	Integer	2	Member's relationship to subscriber
				01 Spouse
				04 Grandfather or Grandmother
				05 Grandson or Granddaughter
				07 Nephew or Niece
				10 Foster Child
				15 Ward
				17 Stepson or Stepdaughter
				19 Child
				20 Employee/Self
				21 Unknown
				22 Handicapped Dependent
				23 Sponsored Dependent
				24 Dependent of a Minor Dependent
				29 Significant Other
				32 Mother
				33 Father
				36 Emancipated Minor
				39 Organ Donor
				40 Cadaver Donor

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
				41 Injured Plaintiff
				43 Child Where Insured Has No Financial Responsibility
				53 Life Partner
				76 Dependent
PC012	**Member Gender**	Integer	1	1 Male
				2 Female
				3 Unknown
PC013	**Member Date of Birth**	Date	8	CCYYMMDD
PC014	**Member City Name of Residence**	Text	30	City name of member
PC015	**Member State**	Text	2	As defined by the US Postal Service
PC016	**Member ZIP Code**	Text	9	ZIP Code of member - may include non-US codes Do not include dash
PC017	**Date Service Approved (AP Date)**	Date	8	CCYYMMDD *(Generally the same as the paid date or the Pharmacy Benefits Manager's billing date)*
PC018	**Pharmacy Number**	Text	30	pharmacy number (NCPDP or NABP)
PC019	**Pharmacy Tax ID Number**	Text	10	Federal taxpayer's identification number *(Please provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.)*
PC020	**Pharmacy Name**	Text	30	Name of pharmacy
PC021	**National Pharmacy ID Number**	Text	20	Required if National Provider ID is mandated for use under HIPAA

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
PC022	**Pharmacy Location City**	Text	30	City name of pharmacy - preferably pharmacy location
PC023	**Pharmacy Location State**	Text	2	As defined by the US Postal Service
PC024	**Pharmacy ZIP Code**	Text	10	ZIP Code of pharmacy - may include non-US codes Do not include dash
PC024A	Pharmacy Country Name	Text	30	Country name of pharmacy
PC025	**Claim Status**	Integer	2	01 Processed as primary
				02 Processed as secondary
				03 Processed as tertiary
				04 Denied
				19 Processed as primary, forwarded to additional payer(s)
				20 Processed as secondary, forwarded to additional payer(s)
				21 Processed as tertiary, forwarded to additional payer(s)
				22 Reversal of previous payment
PC026	**Drug Code**	Text	11	NDC Code
PC027	**Drug Name**	Text	80	Text name of drug
PC028	**New Prescription**	Integer	2	00 New prescription
PC028A	**Refill Number**	Integer	2	01-99 Number of refill
				('01' should be used for all refills, if the specific number of the prescription refill is not available.)
PC029	**Generic Drug Indicator**	Text	1	N No, branded drug
				Y Yes, generic drug
PC030	**Dispense as Written Code**	Integer	1	0 Not dispensed as written
				1 Physician dispense as written
				2 Member dispense as written
				3 Pharmacy dispense as written

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
				4 No generic available
				5 Brand dispensed as generic
				6 Override
				7 Substitution not allowed - brand drug mandated by law
				8 Substitution allowed - generic drug not available in marketplace
				9 Other
PC031	**Compound Drug Indicator**	Text	1	N Non-compound drug
				Y Compound drug
				U Non-specified drug compound
PC032	**Date Prescription Filled**	Date	8	CCYYMMDD
PC033	**Quantity Dispensed**	Integer	5	Number of metric units of medication dispensed
PC034	**Days Supply**	Integer	3	Estimated number of days the prescription will last
PC035	**Charge Amount**	Decimal	10	Do not code decimal point
PC036	**Paid Amount**	Decimal	10	Includes all health plan payments and excludes all member payments
				Do not code decimal point
PC037	**Average Wholesale Price (AWP)**	Decimal	10	Cost of the drug dispensed
				Do not code decimal point
PC038	**Postage Amount Claimed**	Decimal	10	Do not code decimal point
PC039	**Dispensing Fee**	Decimal	10	Do not code decimal point
PC040	**Copay Amount**	Decimal	10	The preset, fixed dollar amount for which the individual is responsible
				Do not code decimal point

Data Element#	Element	Type	Max. Length	Description/Codes/Sources
PC041	**Coinsurance Amount**	Decimal	10	Do not code decimal point
PC042	**Deductible Amount**	Decimal	10	Do not code decimal point
PC043	**Record Type**	Text	2	PC

c. The pharmacy claims file shall be mapped to a national standard as follows:

Table 22 Pharmacy Claims File Mapping

Data Element #	Element	National Council for Prescription Drug Programs Field #
PC001	**Payer**	N/A
PC002	**Plan ID**	N/A
PC003	**Insurance Type/Product Code**	N/A
PC004	**Payer Claim Control Number**	N/A
PC005	**Line Counter**	N/A
PC006	**Insured Group Number**	301-C1
PC007	**Encrypted Subscriber Unique Identification Number**	302-C2
PC008	**Plan Specific Contract Number**	N/A
PC009	**Member Suffix or Sequence Number**	N/A
PC010	**Member Identification Code**	302-CY
PC011	**Individual Relationship Code**	306-C6
PC012	**Member Gender**	305-C5
PC013	**Member Date of Birth**	304-C4
PC014	**Member City Name of Residence**	323-CN
PC015	**Member State or Province**	324-CO
PC016	**Member ZIP Code**	325-CP
PC017	**Date Service Approved (AP Date)**	N/A
PC018	**Pharmacy Number**	202-B2
PC019	**Pharmacy Tax ID Number**	N/A
PC020	**Pharmacy Name**	833-5P
PC021	**National Pharmacy ID Number**	N/A
PC022	**Pharmacy Location City**	831-5N
PC023	**Pharmacy Location State**	832-6F
PC024	**Pharmacy ZIP Code**	835-5R
PC025	**Claim Status**	N/A
PC026	**Drug Code**	407-D7
PC027	**Drug Name**	516-FG
PC028	**New Prescription**	403-D3
PC029	**Generic Drug Indicator**	N/A
PC030	**Dispense as Written Code**	408-D8
PC031	**Compound Drug Indicator**	406-D6
PC032	**Date Prescription Filled**	401-D1
PC033	**Quantity Dispensed**	442-E7
PC034	**Days Supply**	405-D5
PC035	**Charge Amount**	804-5B
PC036	**Paid Amount**	509-F9
PC037	**Ingredient Cost/List Price**	506-F6
PC038	**Postage Amount Claimed**	428-DS
PC039	**Dispensing Fee**	507-F7
PC040	**Copay Amount**	518-FI

PC041	**Coinsurance Amount**	518-FI

PC042	**Deductible Amount**	505-F5
PC043	**Record Type**	N/A

129 CMR 2.12 SOURCE CODES

(1) **Admission Source Code (Data Element: MC021)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining who recommended admission to a medical facility.

(2) **Admission Type Code (Data Element: MC020)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining the priority of the admission to a medical facility.

(3) **Current Procedural Terminology (CPT) Codes (Data Element: MC055)**

SOURCE: Physicians' Current Procedural Terminology (CPT) Manual

AVAILABLE FROM:
Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

(4) **Health Care Common Procedural Coding System (Data Element: MC055)**

SOURCE: Health Care Common Procedural Coding System

AVAILABLE FROM:
www.cms.gov/medicare/hcpcs.htm
Centers for Medicare and Medicaid Services
Center for Health Plans and Providers

CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

(5) **Centers for Medicare and Medicaid Services National Plan ID (Data Elements: DC002, HD003, MC002, ME002, PC002, TR003)**

SOURCE: Plan ID Database

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Centers for Beneficiary Services
Administration Group
Division of Membership Operations
SI-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the Plan ID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

(6) **Centers for Medicare and Medicaid Services National Provider Identifier (Data Elements: DC020, MC026)**

SOURCE: National Provider System

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Office of Information Services
Security and Standards Group
Director, Division of Health Care Information Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the National Provider Identifiers, which is proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

(7) **International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure (Data Elements: MC040, MC041, MC043, MC044, MC045, MC046, MC047, MC048, MC049, MC050, MC051, MC052, MC053, MC058)**

SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

AVAILABLE FROM:

U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

(8) **National Association of Boards of Pharmacy Number (Data Element: PC021)**

SOURCE: National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM:
National Council for Prescription Drug Program
4201 North 24th Street
Suite 365
Phoenix, AZ 85016

ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

(9) **National Association of Insurance Commissioners (NAIC) Code (Data Elements: DC001, HD002, MC001, ME001, PC001, TR002)**

SOURCE: National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM:
National Association of Insurance Commissioners
Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT: Codes that uniquely identify each insurance company.

(10) **National Drug Code (Data Element: PC026)**

SOURCE: Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM:
First Databank, The Hearst Corporation
1111 Bayhill Drive

San Bruno, CA 94066

ABSTRACT: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

(11) **National Uniform Billing Committee (NUBC) Codes (Data Element: MC054)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

(12) **Discharge Status Code (Data Element: MC023)**

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes indicating member status as of the date of service-thru field.

(13) **States and Outlying Areas of the U.S. (Data Elements: DC015, DC028, MC015, MC034, ME016, PC015, PC023)**

SOURCE: National Zip Code and Post Office Directory

AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S. Microfiche.

(14) **Uniform Billing Claim Form Bill Type (Data Element: MC036)**

SOURCE: National Uniform Billing Data Element Specifications Type of Bill Positions 1 and 2

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes describing the type of medical facility.

(15) **X12 Directories**

SOURCE: X12.3 Data Element Directory; X12.22 Segment Directory

AVAILABLE FROM:
Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT: The data element directory contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment director contains the format and definitions of the data segments used to construct the X12 transaction sets.

(16) **ZIP Code (Data Elements: DC016, DC029, MC016, MC035, ME017, PC016, PC024)**

SOURCE: National Zip Code and Post Office Directory, Publication 65, The USPS Domestic Mail Manual

AVAILABLE FROM:
U.S. Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT: The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the nine digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery service area. The two leftmost digits identify a sector that may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes. The USPS Domestics Mail Manual includes information on the use of the new 11-digit ZIP code.

(17) Race and Ethnicity Codes (Data Elements: ME020, ME021, ME022, ME023, ME024, ME025, ME026, and ME027)

Source: Massachusetts Division of Health Care Finance and Policy
Hospital Inpatient Discharge Data
Electronic Records Submission Specification, September 2006

And Hierarchy for Reporting Ethnicity, September 14, 2006

Available from:
Massachusetts Division of Health Care Finance and Policy
2 Boylston Street
Boston, MA 02116

ABSTRACT: This document provides the technical and data specifications, including edit specifications, required for the Massachusetts Hospital Inpatient Discharge Data.

129 CMR 2.13 ADMINISTRATIVE AND TECHNICAL BULLETINS AND SEVERABILITY

(1) Administrative and Technical Information Bulletins. The Council may revise the specifications or other administrative requirements from time to time by notice or administrative bulletin

(2) Severability. The provisions of 129 CMR 1.00 are declared to be severable and if any such provisions or the application of such provisions to any carrier or circumstances are held invalid or unconstitutional, such invalidity or unconstitutionality shall not be construed to affect the validity or unconstitutionality of any of the remaining provisions of 129 CMR 1.00 or of such provisions to carrier or circumstances other than those as to which it is held invalid.